Missouri Health Information Exchange
Regional Listening Sessions
Group Discussion Notes from Kansas City – August 11, 2009

1. Briefly describe a future vision for a Missouri Health Information Exchange (HIE). What goals should be accomplished as Missouri develops a strategic roadmap for Health Information Technology (HIT) and Health Information Exchange (HIE) in the state?

- Achieving meaningful use criteria. Need to be prepared that hospitals will have hard time creating meaningful use criteria.
- Intermediary step: Find out how many people/groups working on non-repository
- It would be easier to have numerous repositories – the goal should be full HIE
- The vault is easier access quicker- from an IT perspective.
- How to access multi-state? Could have alpha numeric id#. Will need to be mandated.
- Need to determine what is the end game? What steps need to be taken or if it is straight to the end result. HINI will this be forgotten if not enacted before.
- How can you create the same vault for all states?
- Linda, a physician in New York – took 3 years to achieve EHR to HIE (example)
- National Standardization – interstate operable
- Missouri and Kansas need to have a collaborative approach.
- There needs to be Recognition of Regional Initiatives since there are differences across state lines and recognition that healthcare is local since needs may be different.
- Emergency response needs to be local
- Local Health planning. It is easier to plan at the local level and have access to the information.
- Important to leverage existing resources across the state
- Need to expand the party's involvement to include continuum of care
- Improve care, decrease costs, increase access.
- Vision/Goals: Reduce Costs and duplication of services
- A clear HIE message
- Getting right info at the right time to engage patients in their healthcare. Easy access
- Chronic Disease Management
- Health Department Notifications (Disease Surveillance)
- Better value to patient care at least cost possible
- A medical service bus/broker based on the phase/financial needs across the state and national levels.
- State role – education and adherence of HIE standards
- Must have quality component for physicians, hospitals, state, health insurance
- Public reporting quality data
- Must have experienced analytical component
- Knowledge about HEDIS, NCQA, NQF criteria
- Quality improvement programs i.e. took kits to improve scores
- Resources for provider education in improving performance and practice
- Use existing resources – don't reinvent the wheel
- Consumer engagement
- Provider involvement money and peer pressure
- Medicaid is critical lynchpin to a successful MO HIE
- Sustainability plan
- Political will to appropriate or find match requirements
- Linkage of benefits with fee structure – shared responsibility for financial commitment to HIE's success.
- Access everyone's medical data and eliminate duplication of service, all providers know what services are provided by others
- Behavioral health info must be included – continuity of care across types of services/care transdisciplinary. Take an opt in approach
- Vision would include privacy and security considerations
- Vision across a person's life span
- Vision across geographic boundaries
- What are the goals – better health care for patient, preventative, reducing health care costs
- Goals – include reimbursement for provider goals – set up HIE to be successful
- Start outcomes and work backwards
- Disease management
- Coordination of care
- Interoperability – base system of exchange
- Agreed definitions and terminology
- State-wide, but meets unique needs of regions with urban, non-urban in the state
- Specialty hospitals, which serves large areas, have access to data from other regions
- Common sharing agreements understand where data going and how it is being used
- Connect to federal systems; VA, DOD, SSA, etc.
- MPI/RLS infrastructure
- TPL eligibility/enrollment

2. What roles are critical for a statewide Health Information Exchange (HIE)?

- National Standards – states for vault repository.
- National Standardization process for Rx, check for Rx – how to they access history
- Indiana & Wisconsin have had HIE – Fed should look to them for template they had for 10 years.
- Talk about business technology very early.
- Two National Standards: 1) Data transfer; 2) Patient locator
- Organization to oversee give tools to work quickly. Responsible for assisting providers in meeting meaningful use criteria
- Act collaboratively with other Hi-tech programs-coordination
- Establish general guidelines, governance.
- Establish and promote data exchange framework
- Technical- assist with other HITECH services (REC program)
- Education of consumers of their role
- Explore HIE to include/offer PHR
- Operations – overseeing data sharing across the state; help to promote exchange, assist in quality measures for health planning
- Education, adherence to HIE standards
- Standardize medical data bus (brokerage)
- Quality reporting and benchmarking
- Building trust among Providers for sharing data
- "Safe Harbors" Tort reform, Information Breach Insurance,
- Level of Liability as the data moves out of the Health Care Facility
- Funding
- Standardization of Government Reports.
- Oversight and governance w/governor at helm
- Someone responsible for technology
- Transparency
- Oversight of privacy and security at State level
- Compliance accountability of providers mandatory or voluntary
- Connecting to federal exchange
- Fee collector
- Marketing and communications to increase participation
- Reporting quality data
- Coordinating efforts within state and across states
- Lobby for national standards protocols and technology
- Education – tailored for various audiences
- Training – all inclusive medical behavioral, dental, pharmacies, social services, lab, etc.
- Organization
- HIE be supportive, collaborative across providers – host provider user group, determine what will motivate various stakeholders to participate in HIE
- Ability for patients to add info to other own record, i.e. over counter meds, exercise, validate information.
- Oversight for standards
- Steering Coordinator
- Common Interests – move forward
- Concerns of stakeholders – system users large and small
- Non-partisan custodian of data repository/exchange
- Financial conduit or executor fiduciary responsibility
- Aggregation of diversified data
- Coaches back to users and health care consumer

- Specify encourage support federal standards, consistency between and within state
- Insure own sustainability by region
- Pick up regional gap between regional
- Assist legal efforts, especially rural as needed
- Support REC efforts to reach physicians in rural areas
- Dentists/mental health unclear, doctors, NP's w/30% Medicaid threshold not met, role of free health clinics.

3. What are you most concerned about related to Health Information Exchange (HIE)?

- Are we just getting clinical data, or are we getting global health status.
- Can we access health statistics?
- Public Health – it should be Public Health friendly. Epidemiology surveillance.
- Employer's access – for example did employees obtain flu shot.
- Provide Communications – accountability
- Time and resources at the state level
- Governance structure
- Shift how we think about data – data ownership
- Primacy & security
- All payers need to pay for the benefits that they will receive
- Broaden the continuum of care
- Sustainability
- Risk of driving efficiencies to reduce volume is out of step with the current funding model.
- Governance of the HIE
- Quality Reporting
- Liability
- Funding
- Future Business model is a concern
- Physicians and ER must participate in the adoption of the HIE.
- Physician Adoption of HIE
- Transparency – who is looking at the data.
- Provider participation
- Who pays for what
- Patient identification
- Can we meet the meaningful use timeline
- Sharing date with immature HIE's – don't have good framework yet
- Get value for our organization – for patients and providers
- Trust the data to make good patient care decisions
- Won't impact real change in healthcare delivery
- There won't be an HIE to connect to in the current timeline
- Who are stakeholders – will behavioral health be involved
- Infrastructure – make sure all providers have access to HIE
- Ability to transition from paper to electronic
- Medicaid and Medicare – will there be sufficient incentive to get providers to participate?
- Security
- Privacy
- Ability to get a second opinion
- Concern if HIE became a gatekeeper or enabled development of a gatekeeper
- Liability – provider's liability for the data in the HIE
- Patient's Rights – how does patient control who can see what data?
- Sustainability – not just HIE, but the participants, the relationship with the HIE
- Cost of technology, maintenance, upgrades
- Developing and maintaining momentum
- $ plus resources
- Disparate data
- Data Integrity
- Privacy and security
- State to state differences
- Long term commitment
- Organizational fatigue
- Long delay in new adoption while we wait on agreements
- Competing projects and priorities (ICD10, updated HIPAA
- Adoption by older physicians; in hospital, employed physicians, system and stand-alone, small practices sold
- Sustainability - accounting of cost savings, fees
- Privacy and security
- Liability issues (case law)
- Governance structure – who gets a seat; participates, funding, politics, etc. criteria
- Technical application model – federated vs. data bank (hybrid)
- Behavioral health – chiropractors, other groups
- Left out of phase I in HIE's
- Take a lot of time and money and do not show progress

4. What general comments do you have related to Health Information Exchange (HIE)? What other questions do you have?

• Caution – too much discussion – people (stakeholders) need to be very honest • Need readiness to change • Within 5 years we may see small physician offices migrating to hospital based. • Have to collaborate • Change of data sharing paradigm • Necessary to create a legislative environment that encourages opportunity to HIE • No Notes – Did not address • Built on flexible, sustainable platforms • Stability with change in political priorities • Appreciative of opportunity to share our thoughts • Suggestions for State Advisory Committee (no more than 10) o Employer o Hospital o Physician Representative o Quality o Technology o Consumer o Privacy and Security • How can we piggyback on the MO Medicaid investment? • Develop asset inventory – consider their assets and relationships when a state plan is developed • Considering state line issue • Must improve care at individual patient level • Consensus • Buy-in • Cross state issues • Benefit the most at some level to begin with • Duplication of collections reporting methods; HEDIS, MEPS, CCIP, state data collection • Consumer fear for shared data in a way they cannot control • More compliance and regulations • Valuable in some case, e.g. fraud abuse, frequent Perk flyers/chronic disease management • Behavioral health – not a lot of practioners using EAR's, protection of patient's information • Buy-in cost reasonable for physicians to start-up and participate	